Kindergarten Health History Form

Child’s name ___________________________  Male/Female (circle one)  Birthdate ___
Mother’s Name ___________________  Father’s Name ___________________

With whom does the child live? ______________________________
Who is the child’s legal guardian? ______________________________

Perinatal/Developmental History

Infant born:  Full Term or Premature (circle one)  Birth weight: __________
Any illness or problems while in the Nursery? ______________________________
Approximate age at which this child:
  Walked alone ______    Toilet Trained______    Spoke in Sentences_____
  Dressed self ______    How does this child’s development compare to
  Brothers/sisters or playmates?    About the same  slower  faster (circle one)

Medical History

1. Health Conditions:   ____________________________________________________
   ______________________________________________________________________

2. History of Hospitalization:   ____________________________________________
   ______________________________________________________________________

3. Allergies: (food, plant, animal, drug) _____________________________________
   ______________________________________________________________________

4. Childhood Diseases: (i.e. chicken pox) _____________________________________
   ______________________________________________________________________

5. Medication: (taken on a regular basis) _____________________________________
   ______________________________________________________________________

6. Does this child receive special services (i.e. speech, physical therapy)? If so, please explain
   ______________________________________________________________________

Do you have other comments about this child’s health, development, behavior, family or home life that you feel the school should be aware of? If so, please explain briefly:
   ______________________________________________________________________
   ______________________________________________________________________

Completed by: ____________________ (relationship to child) ___________  Date _____
Dentist’s Report for Kindergarten

Child’s Name_______________________                    Age_______(years) ______ mos.

Dentist Name____________________
Address        _____________________
Phone           _____________________

Date of last exam________

Findings________________________________________________________________
_______________________________________________________________________

Signature of Dentist___________________                          Date__________
Physician’s Report for Kindergarten

Child’s Name_____________________________   Age ______(years) ______(mos.)

Immunization Requirements: at least 5 DPT, 4 polio, 2 MMR, 3 or 4 Hep. B, 2 Varicella, and 4 HIB (The fourth dose of polio administered on or after the fourth birthday)

DPT  1._____  2._____  3._____  4._____  5._____  
Polio  1._____  2._____  3._____  4._____  
MMR  1._____  2._____  
HIB  1._____  2._____  3._____  4._____  
Hep B  1._____  2._____  3._____  4._____  
Varicella  1._____  2._____  

Other   Type______________  Date______          Type______________  Date______

Screening Tests:
Vision (pass/fail):  Hearing (pass/fail):  
Distance acuity  R_____ L_____  Pure Tone  R_____ L_____  
Muscle balance  R_____ L_____  Impedence  R_____ L_____  
Farsightedness  R_____ L_____  Frequent Ear Infections? _______  
Color (Circle)  Pass / Fail  Does child have tubes? _______  
Wears glasses? Yes / No  Right______ (date placed)  
Referral made? Yes / No  Left _______ (date placed)  

Allergies:(food, plant, animal, drug)__________________________________________  
_______________________________________________________________________  

Physical Exam:  
Essential Normal _____  Abnormalities as follows: ______________________________
________________________________________________________________________
________________________________________________________________________  

Is this child able to participate in all school activities?  Yes _____  No _____  
If no, please explain:  _____________________________________________________  

This is to certify that the above named student has been seen in our office and is in suitable condition to attend a preschool or kindergarten program.

(PRINT OR STAMP BELOW)

Physician Signature __________________________  Physician name __________________________
Date of exam __________________________  Address __________________________
Phone __________________________  __________________________